Public Act 152 of 2011:
Publicly Funded Health Insurance Contribution Act

Frequently Asked Questions

Q1. When does the benefit plan year begin?

A1. The Publicly Funded Health Insurance Contribution Act provides for certain limitations on the amount that public employers may contribute toward the annual cost of medical benefit plans that cover their employees. The Act applies to "coverage years" beginning on or after January 1, 2012. The Act does not use the term "plan year."

Although "coverage year" is not defined in the Act, Treasury has interpreted this term to mean the one-year period beginning on the date that newly elected or newly renewed coverage begins for a group of persons under a medical benefit plan. Usually, this date is shortly after the annual benefit enrollment period during which employees choose coverage. Therefore, the first "coverage year" under the Act would be the one-year period beginning on the date on or after January 1, 2012 that new medical insurance coverage begins.

Q2. Is "coverage year" the same thing as "plan year"?

A2. The Act does not use the term "plan year." See FAQ1 for an explanation of Treasury's interpretation of the term "coverage year." A medical benefit plan "coverage year" may or may not be the same as the period referred to as a "plan year."

Q3. Does the Act cover plans for dental and vision insurance?

A3. No. A "medical benefit plan" is defined under the Act as "a plan … that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits …." Treasury has interpreted this definition to exclude separate plans for dental or vision insurance.

Q4. A public employer has not elected to comply with Section 4 of the Act (providing for percentage-based limitations on contributions), and is therefore subject to the requirements of Section 3 (providing for cap-based limitations on contributions). If the employer's contribution equals (but does not exceed) the full capped amount but the amount that employees pay is less than 20% of the total annual costs of their medical benefit plan, is the employer in compliance with the Act?

A4. Yes. Public employers must comply with Section 3 of the Act (providing for capped contributions to medical benefit plans offered to employees) unless they elect instead to

comply with Section 4 (providing that they may not pay more than 80% of the total annual costs of all medical benefit plans offered to employees). Accordingly, for any coverage year, an employer is subject to either the Section 3 limitations, or the Section 4 limitations. The two separate types of limitations do not apply at the same time.

Q5. The benefit year under our medical plan is July 1 – June 30, but deductibles begin accruing on January 1. On what date must we be in compliance with the Act for our medical plan?

A5. The Act does not use the term "benefit year," but instead uses the term "coverage year." The "coverage year" is the period that is applicable for determining compliance with the Act, even if the accrual of deductibles is tied to a different period. See FAQ1 for an explanation of Treasury's interpretation of the term "coverage year."

Q6. Is the medical plan year referenced in the Act the plan year, the contract year, or the deductible year?

A6. The Act uses the term "coverage year" rather than "plan year," "contract year," or "deductible year." See FAQ1 for an explanation of Treasury's interpretation of the term "coverage year."

Q7. Can a local unit of government use its fiscal year to determine the annual cap calculation under Section 3?

A7. No. The caps under Section 3 apply to each medical benefit plan "coverage year" beginning on or after January 1, 2012, and the caps are based upon the number of employees with single person, individual and spouse, and family insurance coverage. Therefore, the calculation of the caps must be tied to the period of insurance coverage. Specifically, the cap calculation must be made for the same period as the medical benefit plan "coverage year." See FAQ1 for an explanation of Treasury's interpretation of the term "coverage year."

Q8. A) Can a public employer choose to have one collective bargaining unit fall under Section 3 of the Act and another collective bargaining unit fall under Section 4?
B) Can subdivisions of collective bargaining units fall under different sections?

A) No. Section 4(2) of the Act provides that when a public employer has elected to have Section 4 of the Act apply (if a local unit of government elects this "opt-out" provision, then it must pass a resolution each year), it shall pay not more than 80% of the total annual costs of "all of the medical benefit plans" it offers or contributes to.. The implication of this language is that an election to comply with Section 4 of the Act (rather than Section 3) affects all of the public employer's medical benefit plans (if it has more than one). Section 4(2) of the Act also provides that where the public employer elects to comply with Section 4 of the Act, any elected public official who participates in "a medical benefit plan" offered by the public employer must pay at least 20% of the total annual plan costs. Again, this language implicates that an election to comply with Section 4 of the Act affects all of the public employer's medical

benefit plans.

B) No. Subdivisions of collective bargaining units cannot fall under different sections.

Q9. Does the Act cover elected public officials beginning January 1 or July 1?

A9. A public employer must be in compliance with the Act with respect to its medical benefit plans for each "coverage year" beginning on or after January 1, 2012. The date that a particular person, such as an elected public official, would become subject to the requirements of the Act would depend upon the date that the official became covered under the public employer's medical benefit plan.

Q10. If an employee opts out of health insurance coverage, can that employee be calculated into the Section 3 cap amount or does it have to be taken out of calculations for the Section 3 cap?

A10. An employee who has opted out of health insurance coverage cannot be calculated into the cap amount. The caps under Section 3 of the Act apply with respect to each medical benefit plan "coverage year" beginning on or after January 1, 2012, and the caps are based upon the number of employees with varying levels of insurance coverage. An employee who has opted out of health insurance coverage does not have any level of coverage, so cannot be included in the cap calculation. This is true even if the employer makes a payment to the employee in lieu of the employee's participation in the health insurance program.

Q11. Is short or long term disability insurance considered a "related benefit" to be included in making the contribution calculations under the Act?

A11. No. A "medical benefit plan" is defined under the Act as "a plan … that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits …." Treasury has interpreted this definition to exclude plans for short or long term disability insurance.

Q12. Section 3 of the Act specifies a hard cap of $11,000 for individual and spouse coverage and $15,000 for family. Our insurance allows us to insure a single parent plus a child as "individual plus one," but the law specifies individual and spouse. Are we required to use the family coverage figure for calculating the cap for the single parent and child?

A12. The caps in Section 3 of the Act are based upon the typical levels of coverage offered by most medical benefit plans. If a plan offers "individual plus one" coverage for a single parent plus a child that is comparable to the coverage offered for an "individual and spouse," or if a plan offers "individual plus one" coverage for a single parent plus a child in lieu of "individual and spouse" coverage, employees choosing "individual plus one" coverage to insure a single parent plus a child should be included in the cap calculation at the same rate specified for employees with "individual and spouse" coverage.

Q13. Can local units of government elect to comply with Section 4 (providing for contribution limits based on percentages) or exercise the opt-out provision of Section 8 at any point during the year? How is the "year" determined for purposes of exercising these options? Must the local unit of government renew its election to opt out at the same time each year and if so, when?

A13. A public employer must be in compliance with the Act for each "coverage year" beginning on or after January 1, 2012. See FAQ1 for an explanation of Treasury's interpretation of the term "coverage year." The first "coverage year" falling under the Act would be the one-year period beginning on the date on or after January 1, 2012 that new medical insurance coverage begins. A local unit of government may elect to comply with Section 4 or exercise the opt-out provision of Section 8 at any time prior to the beginning of a new "coverage year." The election to opt out must be made separately for each new "coverage year."

Q14. Section 5(2) of the Act specifies that collective bargaining agreements or other contracts executed on or after September 15, 2011 must comply with the requirements of the Act. However, the Act had not been signed into law as of that date. Is that date still effective?

A14. The intent of the Act was to make the requirements of Sections 3 and 4 inapplicable to collective bargaining agreements currently in effect, but to make those sections fully applicable to new collective bargaining agreements, as well as to extensions or renewals of agreements currently in effect. Section 5(1) specifically exempts from compliance collective bargaining agreements that are in effect on the effective date of the Act. Therefore, Section 5(2) should be read to provide that collective bargaining agreements or other contracts executed on or after September 27, 2011 (the actual effective date of the Act) may not include terms that are inconsistent with the requirements of Sections 3 and 4 of the Act.

Q15. May a public employer impose the hard cap requirements of Section 3 or the 80/20 percentage requirements of Section 4 with respect to a group of employees who are covered by a collective bargaining agreement prior to the expiration date of the agreement that is currently in effect?

A15. No, if the imposition of those requirements would be contrary to the terms of the collective bargaining agreement currently in effect. Section 5(1) of the Act exempts collective bargaining agreements that are in effect on the effective date of the Act from compliance with the Act's requirements. Therefore, if the imposition of the new requirements under either Section 3 or Section 4 would be contrary to the terms of the current agreement, an employer may not impose those requirements with respect to a group of employees who are covered by a collective bargaining agreement until the agreement currently in effect has expired, is renewed, or is extended.